June 16, 2003

MDR Tracking #: M2-03-1286-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ sustained a work-related injury on ___ when she stepped off a ladder and missed a step, fell from the rack and injured her head and lower back. The records also indicate that she has had intra-articular steroid injections of the lumbar spine under fluoroscopy in the past which have relieved her symptoms. Injection therapy was sought in the years 2000 and 2001, and were denied. She is currently taking Celebrex or Vioxx.

___ was seen by ___ under the authority of ___

REQUESTED SERVICE

Multilevel facet block under fluoroscopy with IV sedation is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This 39-year-old woman injured her low back in ___. She has recurrent lower back pain with lumbar facet joint arthropathy. Steroid injections in her distant past yielded fairly good long-term pain relief. She ahs ahd reaacurrent lower back pain consistent with lumbar degenerative disc disease.

Based on the medical records provided and the American Academy of Orthopaedic Surgeons and North American Spine Society treatment guidelines, the reviewer finds that the requested facet joint blocks are reasonable and necessary to treat this injured patient's diagnosis. It is clearly documented that this patient has been on anti-inflammatory medicine and has been treated for over ten years with intermittent physical therapy with no long-term relief. The guidelines clearly state that the above-mentioned multi-level facet joint blocks would be warranted.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief

Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).